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October 6, 2016

VIA ELECTRONIC SUBMISSION
http://www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9934-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018 [CMS–9934–P]

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to submit comments in response to the Centers for Medicare & Medicaid Services' (CMS) Proposed Notice of Benefit and Payment Parameters for 2018 (NBPP).[1] Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights serves over two million beneficiaries, caregivers, and professionals through its national helpline and educational programming annually. The undersigned organizations representing older adults, people with disabilities, and their families also support these comments:

American Association on Health and Disability
Association of University Centers on Disabilities
Brain Injury Association of America
California Health Advocates
Families USA
Justice in Aging
National Committee to Preserve Social Security and Medicare
National Council on Aging (NCOA)
National Multiple Sclerosis Society

[1]Centers for Medicare & Medicaid Services (CMS), Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. 61456, September 6, 2016.

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Our response to this request is informed by our experience assisting individuals and their family members as they navigate the transition to Medicare, including for those aging into the program (ages 65 and older), those becoming eligible due to receipt of Social Security disability benefits (SSDI), and those with End Stage Renal Disease (ESRD) who may apply for Medicare. Medicare Rights counsels newly eligible individuals transitioning from, or who have had coverage from, employment, the Federally-Facilitated or a State-based Marketplace, Medicaid, Veterans Administration, TriCare, and/or from other types of coverage.

Medicare enrollment decisions are complex and individually driven, and we consistently find that many current and newly eligible beneficiaries lack complete, unbiased, and accurate information about their options and about the potential consequences of their enrollment choices. Through our national helpline and educational programming, Medicare Rights regularly counsels beneficiaries and family caregivers who are overwhelmed and confused by an array of complex enrollment decisions and obligations.

We continue to strongly urge CMS to advance policies and programs designed to facilitate informed coverage transitions for Marketplace enrollees newly eligible for Medicare. Such initiatives serve a dual purpose—both to secure the long-term sustainability of the Marketplace and to prevent costly enrollment mistakes among people new to Medicare. Importantly, these efforts must take into account differing enrollment rules and considerations for populations who come to Medicare in different ways, including those who age into Medicare, those who receive SSDI, and those who may apply for Medicare due to ESRD.[2]

Since 2013, Medicare Rights and allied organizations have repeatedly raised questions concerning how Affordable Care Act (ACA) rules for Marketplace-issued coverage interact with existing Medicare enrollment, coordination of benefits/Medicare Secondary Payer, and coverage rules.[3] We appreciate that CMS addressed some of these concerns in its publication entitled "Frequently Asked Questions Regarding Medicare and the Marketplace."[4] Yet, as the proposed rule reflects, some significant questions remain.

Our comments on the NBPP focus on section III.C.3.B "Guaranteed Renewability in the Individual Market and Medicare Eligibility." In this section, CMS asks first about the interaction between the guaranteed renewability provisions at 42 CFR § 147.106(h)(2) and the anti-duplication provisions at § 1882(d)(3) of the Social Security Act. Second, CMS inquires about the practice of coordinating benefits with Medicare, even when the enrollee is eligible for but not enrolled in Medicare.

If you have questions about our comments or require additional information, please contact Stacy Sanders, Federal Policy Director, at ssanders@medicarerights.org or 202-637-0961 and Casey Schwarz, Senior Counsel for Education & Federal Policy, at cschwarz@medicarerights.org or 212-204-6271.

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[2] *See*, for example, Medicare Rights' comments on proposed 2017 NBPP (December 2015), available at: http://www.medicarerights.org/pdf/122115-nbpp-comments.pdf and see a letter signed by 40+ leading consumer advocates and health insurers on advance notice and screening for Marketplace enrollees nearing Medicare (December 2015), available at: http://www.medicarerights.org/pdf/122115-marketplace-medicare-nbpp-signon.pdf. Also, see a letter signed by consumer advocates urging better notice for all people nearing Medicare, including those with Marketplace plans (December 2014), available at: http://www.medicarerights.org/pdf/121114-medicare-enrollment-signon-letter.pdf.

[3] *See*, Letter to Administrator Tavenner dated September 30, 2013 from Medicare Rights Center and allied organizations, letter to Administrator Tavenner dated May 1, 2014 from Medicare Rights Center and allied organizations, and letter to memo to CMS staff in response to released Medicare-Marketplace FAQs signed by 15+ consumer advocates.

[4] CMS, "Frequently Asked Questions Regarding Medicare and the Marketplace," (last updated April 2016), available at: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html.

Guaranteed Renewability and Anti-Duplication

The guaranteed renewability provision at 45 CFR § 147.106(h)(2), interpreting 42 USC § 300gg–2 expressly states that Medicare eligibility or entitlement is not a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market. The anti-duplication provision at 42 USC 1395ss(d) prohibits the knowing sale or issuance of an individual health insurance policy to an individual *entitled to benefits under Medicare Part A*—meaning that they have met all of the eligibility requirements for Part A and have applied for Part A or applied for Social Security cash benefits—or *enrolled under Medicare Part B*—meaning they have actually enrolled in Part B.

As the NBPP states, the anti-duplication provision "does not expressly prohibit the renewal of individual health insurance coverage to someone who becomes entitled to benefits under Part A or enrolls under Part B while enrolled in the individual market coverage." The NBPP asks whether "the guaranteed renewability statute and the anti-duplication provision at section 1882(d)(3) of the Act should together be interpreted to require or prohibit renewal of a Medicare beneficiary's individual market coverage, if the issuer has knowledge that the renewed coverage would duplicate the Medicare beneficiary's benefit" in a number of specific renewal circumstances.

Our organizations strongly believe that these laws should be read together to require renewal of individual market coverage. As demonstrated below, this reading is consistent with canons of statutory construction, consistent with longstanding CMS treatment of State guaranteed renewability requirements, and consistent with sound public policy.

First, well-established canons of statutory construction provide that, to the extent various parts of the law can be read to avoid conflict and to avoid nullification, they should be read in that manner. They also provide that remedial statutes, like the Social Security Act and the ACA, should be read broadly to be given their fullest effect.[5] When the reading that avoids conflict is also the interpretation most consistent with the plain language of the law, as here, the choice is even clearer.

The plain language of the anti-duplication provision prohibits the "sale or issuance" of a policy that is duplicative of benefits under the Medicare program.[6] The guaranteed renewability provisions of the ACA expressly list certain acceptable bases for a plan to "nonrenew" or "terminate" coverage.[7] Eligibility for, or enrollment in, another form of coverage is not listed as one of the acceptable reasons for nonrenewal or termination.[8] Common usage does not conflate "renewal" and "sale or issuance."

Indeed, if "renewal" and "sale or issuance" meant the same thing, the previous section of the law, 42 USC § 300gg–1, which provides for "guaranteed issuance of coverage in the individual and group market" would either have no meaning or would be redundant to, and contradict, the provisions, 42 USC § 300gg-2, that address renewability.[9] Alternatively, if the words "sale or issuance" and "nonrenew" are given their usual meaning, all of the relevant sections of the law have meaning.

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[5] *See*, L.M Eig., "Statutory Interpretation: General Principles and Recent Trends," (Congressional Research Service: December 2011), available at: https://www.fas.org/sgp/crs/misc/97-589.pdf.

[6] 42 USC § 1395ss(d)(3).

[7] 42 USC § 300gg-2(b).

[8] *Id.*

[9] *Id* and § 300gg-1.

Conflict between the anti-duplication provisions and the guaranteed renewability provision is easily avoided by giving the critical words their usual meaning. Because the agency can—and currently[10]—read(s) the anti-duplication provision to apply only to the initial issuance of coverage, it should do so to give full effect to the protective elements of both the anti-duplication rule and the guaranteed renewability protections.

It is also important to note that by its terms, the anti-duplication provision does not apply to people who might be or are likely eligible for Medicare, but who are not enrolled in either Medicare Part A or Part B. This includes people with ESRD who might apply for Medicare benefits and people over age 65 who must pay a premium for Part A and have not applied for or enrolled in either Medicare Part A or Part B. Given this, any perceived conflict between the anti-duplication and guaranteed renewability provisions would be irrelevant to the applicability of guaranteed renewability for these populations.

Second, this interpretation, which prohibits the sale of policies to those already enrolled in Medicare but protects the renewability of policies sold to individuals prior to their eligibility, is long standing. Most states, including New York, Arizona, and Michigan have had guaranteed renewability provisions for individual health insurance policies that pre-date the ACA[11] and which ensure the renewability of private market plans above the floor set in § 2742 of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.[12]

In these states, guaranteed renewability means that individuals who have purchased private, individual market health insurance plans prior to their enrollment into Medicare are able to keep those policies as secondary coverage once they become Medicare eligible. In some instances, the fact that individuals who retained such coverage would be unable to obtain new coverage because of the anti-duplication provisions resulted in restructuring State and CMS approved business transformations (for example, in the conversion of non-profit insurers with a social mission to provide coverage to hard-to-insure populations to for-profit entities with no such mission) in order to protect coverage that could be retained, but could not be newly issued. In other words, the perceived conflict between the anti-duplication and guaranteed renewability provisions has been effectively and historically managed by treating the sale of coverage as distinct from its renewal.

Finally, it is sound public policy to require the renewal of individual market Qualified Health Plans (QHPs). Our organizations maintain that most people eligible for Medicare who are currently enrolled in individual market QHPs should enroll in both Medicare Part A and Part B. As discussed below, the majority of individuals eligible for Medicare face significant risks when they retain individual market coverage. Yet, there are important exceptions to this general rule—including people eligible for ESRD Medicare and those ineligible for premium-free Part A—for whom enrollment rules and affordability considerations significantly differ. Further, the option to retain Marketplace coverage is important not only for the small number of people who fall into these exception categories, but also for those who make Medicare enrollment mistakes while transitioning from the Marketplace to Medicare.

Understanding when such exceptions to the general rules apply to a particular person's situation adds to the already complicated decision-making and transition-management process that people approaching Medicare eligibility must navigate. People with Marketplace coverage nearing Medicare eligibility face many obligations, namely concerning

[10] *See*, CMS, "Frequently Asked Questions Regarding Medicare and the Marketplace," last updated April 2016), available at: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html at A8.
[11] National Conference of State Legislatures (NCSL), "State Reform Initiatives in Effect Before and During the ACA," available at: http://www.ncsl.org/research/health/individual-health-insurance-in-the-states.aspx; Patel, V. and M.V. Pauly, "Guaranteed Renewability And The Problem Of Risk Variation In Individual Health Insurance Markets," *Health Affairs* (August 2002), available at: http://content.healthaffairs.org/content/suppl/2003/12/03/hlthaff.w2.280v1.DC1; *See e.g.* 516 MPA § 550.1401e
[12] 42 USC § 300gg–42; Patel, V. and M.V. Pauly (August 2002).

whether and when to enroll in Medicare and cancel their Marketplace plan. Despite these responsibilities, people with Marketplace plans receive minimal to no notice about their Medicare eligibility unless they are auto-enrolled in Medicare because they receive Social Security cash benefits. In addition, Marketplace enrollees receive minimal to no notification that their access to Advanced Premium Tax Credits (APTCs) automatically terminates when they become Medicare eligible, though there are some notable exceptions. [13] CMS only recently began sending one email to enrollees with APTCs in the Federally-Facilitated Marketplace who are approaching age 65 about the likelihood of their upcoming Medicare eligibility.[14]

These notification gaps put people in the Marketplace who are nearing Medicare eligibility at risk. Honest enrollment mistakes can lead to lifetime Part B premium penalties, gaps in coverage, disruptions in accessing needed care, and tax penalties. To avoid these consequences, it is imperative that CMS develop a multi-pronged system to adequately screen, notify, and educate individuals about how and when to transition from the Marketplace to Medicare. We urge CMS to ensure that all individuals nearing Medicare eligibility who are enrolled in Marketplace plans receive adequate notification outlining basic Medicare enrollment rules, alerting enrollees to the possible loss of APTCs, and explaining the potential consequences of delayed Medicare enrollment.

Further, we urge CMS, as operator of the Federally-Facilitated Marketplace, to screen individuals for nearing Medicare eligibility, just as it screens for other forms of coverage, including expansion Medicaid and the Children's Health Insurance Program (CHIP). CMS should also issue regulations requiring screening for approaching Medicare eligibility by State Marketplaces. With screening, these people can be targeted for pre-eligibility education on Medicare to allow them to make informed choices. A comprehensive screening and notification system will help beneficiaries avoid costly enrollment mistakes, and we believe unbiased information about their coverage options will convince most to voluntarily terminate unnecessarily duplicative Marketplace coverage.

Absent this multi-pronged system, we continue to observe that many newly eligible Medicare beneficiaries mistakenly delay Medicare enrollment altogether or enroll only in Medicare Part A, declining Medicare Part B. These individuals are ineligible for APTCs, face potential lifetime Part B late enrollment penalties, and must wait until the January to March General Enrollment Period (GEP) to enroll in Medicare Part B for outpatient coverage starting in July. Further, those with only Part A who previously declined Part B are barred by the anti-duplication provision from purchasing any health insurance coverage in the interim. Being able to continue Marketplace coverage is, therefore, essential for both those who erroneously delay both Medicare Part A and Part B as well as those who enroll in Medicare Part A and mistakenly decline Part B.

CMS has acknowledged how crucial retaining QHP coverage is for a person who has missed their Initial Enrollment Period (IEP) for Part B and faces a gap in coverage during which they cannot purchase new coverage. In the new notice to individuals identified through Periodic Data Matching (PDM) as being enrolled in Medicare and also receiving APTCs in the Federally-Facilitated Marketplace[15] CMS writes:

> If you have premium-free Medicare Part A but don't have Part B:

[13] Individuals with APTCs can retain APTCs so long as they do not enroll in Part A if they are ineligible for premium-free Part A or if they are potentially eligible for Medicare on the basis of ESRD. See, IRS, "Eligibility for Minimum Essential Coverage for Purposes of the Premium Tax Credit, Notice 2013-41" (August 2013), available at: http://www.irs.gov/pub/irs-drop/n-13-41.pdf

[14] CMS, "Press Release: Strengthening the Marketplace – Actions to Improve the Risk Pool," (June 2016), available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-08.html

[15] CMS, "Medicare Periodic Data Matching (PDM)," (August 2016), available at: https://marketplace.cms.gov/technical-assistance-resources/medicare-periodic-data-matching.pdf

> You should end any advance payments of the premium tax credit that you may be receiving for a Marketplace plan immediately. . . You may want to stay in your Marketplace plan temporarily without advance payments of the premium tax credit or cost-sharing reductions, depending on when you turned 65:
> . . .
>
> If your 65th birthday was more than 3 months ago, many people will want to enroll in Medicare Part B during the next general enrollment period (January –March 2017) and then end their Marketplace coverage. Your Medicare Part B coverage will begin July 1 of the year you enroll in Medicare Part B.
>
> If you want to enroll in Medicare Part B and end Marketplace coverage, contact the Marketplace at least 15 days before your Medicare Part B coverage starts to end your Marketplace coverage. Usually you'll want your Marketplace coverage to end the day before your Medicare Part B coverage starts.[16]

We greatly appreciate the agency's recent efforts to notify Federally-Facilitated Marketplace enrollees approaching age 65 (through email) and to identify and notify individuals over age 65 dually enrolled in the Marketplace and Medicare (in writing) about eligibility concerns related to their likely ineligibility for APTCs through a pilot program.[17] Still, more can and should be done to facilitate appropriate and informed coverage transitions among Marketplace enrollees eligible for Medicare. **As next steps, we strongly encourage CMS to identify mechanisms to notify those approaching age 65 with written notice (ideally multiple) and to incorporate those nearing eligibility for SSDI-based Medicare and ESRD Medicare in future phases of the pilot program.**

The NBPP specifically asks how requiring or prohibiting renewal could affect Medicare enrollment decision-making. This question seemingly assumes that Marketplace enrollees are educated about their Medicare choices and make informed decisions weighing all of the consequences, such as late enrollment penalties and potential gaps in coverage, when they decline or delay Medicare enrollment. Yet, our experience consistently reflects otherwise and, as a result, far too many older adults and people with disabilities are caught unaware and face significant hardship—stemming from late enrollment penalties, gaps in coverage, higher healthcare costs, and more.

Allowing individual market QHPs to terminate coverage for individuals eligible for Medicare would only exacerbate harms resulting from Medicare enrollment errors, namely by eliminating an essential coverage option for those facing a lengthy gap in Part B coverage. **As outlined above, we do not support revisiting the long-standing interpretation of the guaranteed renewability provisions that requires QHP renewals for individuals eligible for Medicare, and we are deeply concerned by the precedent such an interpretation would set.**

Coordination of Benefits and Medicare Secondary Payer

As described in the NBPP, "…since Medicare Secondary Payer rules do not apply to health coverage in the individual health insurance market, Medicare always pays primary to individual health insurance coverage. Some issuers have a provision in their individual health insurance policies indicating that the coverage will pay secondary

[16] *See*, Medicare PDM notice (September 2016), available at: https://marketplace.cms.gov/applications-and-forms/medicare-pdm-notice.pdf
[17] *See*, CMS, "Medicare Periodic Data Matching (PDM)," (August 2016), available at: https://marketplace.cms.gov/technical-assistance-resources/medicare-periodic-data-matching.pdf and CMS, "Press Release: Strengthening the Marketplace – Actions to Improve the Risk Pool," (June 2016), available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-08.html

to Medicare not only for individuals who are currently covered by Medicare but also for those who could obtain Medicare coverage (such as those individuals who must pay for Part A coverage) but who are not currently covered." CMS solicits comments on the effects of such provisions on consumers, on Medicare, and the individual market, and whether this is a permissible coordination of benefits provision.

Our organizations greatly appreciate CMS' request for input on this matter. The aforementioned policies, by which an insurer coordinates with an insurance policy that does not actually provide coverage—essentially "phantom coordination"—can cause significant harm to consumers. We regularly hear from individuals who misunderstood or were altogether unaware of similar coordination of benefits rules related to their retiree or COBRA coverage. As a result, despite paying insurance premiums, these individuals may face significant out-of-pocket expenses when their insurer refuses to pay as primary because they are not enrolled in Medicare Part B.[18]

To date, Medicare Rights has not directly encountered cases where Marketplace-based QHPs similarly refuse to pay, but we are very concerned about the possibility that Marketplace enrollees may be paying significant premiums for coverage that does not provide sufficient—or any—benefits, depending entirely on their insurer's rights and discretion.

Unlike for employer-sponsored health coverage for employees of certain-sized employers, there is no federal law regarding the order of insurance payments for individual market health coverage. Instead, our organizations look to the National Association of Insurance Commissioners (NAIC) Model Rules for Coordination of Benefits (COB). Currently, forty states have adopted NAIC model COB rules,[19] which provide model language addressing the coverage of individuals who are covered by more than one insurance plan, including Medicare.[20] The model outlines the order in which benefits are paid and the amount for which each plan, including Medicare, is responsible.[21] The COB section of the model states:

> A COB provision may not be used that permits a plan to reduce its benefits on the basis that:
>
> (1) Another plan exists and the covered person did not enroll in that plan;
>
> (2) A person is or could have been covered under another plan, ***except with respect to Part B of Medicare***; or
>
> (3) A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.[22]

In states that have adopted the NAIC model rules, certain insurance plans, including individual market plans, group retiree, and small group employer-based coverage,[23] may provide *only secondary coverage* to individuals who are *eligible* for Part B, even if they are not enrolled. Based solely on these COB rules, an individual market QHP could pay claims as a secondary insurer even absent actual enrollment in and payment of claims by Medicare Part B. For example, if an individual had *only* an individual market QHP and Medicare Part A and incurred a Part B outpatient

[18] *See*, Medicare Rights Center, "A Costly Mistake: Missing Part B Enrollment," (April 2015), available at: https://www.medicarerights.org/medicare-snapshot-april-2015; S. Sanders, "Medicare Part B Enrollment: Pitfalls, Problems, and Penalties," (November 2014), available at: http://www.medicarerights.org/pdf/PartB-Enrollment-Pitfalls-Problems-and-Penalites.pdf

[19] Forty states, including: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin, and Wyoming.

[20] NAIC, Group COB Model Regulations. § II; NAIC, Group COB Model Reg. § III (K)(3).

[21] NAIC, Group COB Model Regulation § III (K)(3)(g).

[22] NAIC, Group COB Model Regulation § V(D).

[23] *Id.*

claim, the QHP could choose to pay only the portion it would have paid had the person been enrolled in Part B or could choose not to pay at all.

Yet, such a refusal likely violates the essential health benefits and actuarial value requirements under the ACA. As CMS reasons in its Frequently Asked Question (FAQ) with regard to small employer group health plans sold through the Small Business Health Options Program (SHOP)—which, under the NAIC COB rules, could reduce payments if a person was eligible but not enrolled in Medicare Part B—an "…insurance plan may not limit coverage based on the theoretical possibility of an individual's enrollment in other coverage…" because of those provisions of the ACA. The FAQ goes on to state that "…modifying a benefit design based on Medicare eligibility could be considered discriminatory in violation of the federal non-discrimination prohibitions."[24] This reasoning applies equally well to individual market QHPs as it does to small group employer SHOP plans because both of these types of plans are treated identically by the Medicare Secondary Payer statute[25] and the NAIC model rules.[26]

The NBPP specifically asks how the appropriateness of such a policy would affect individual's enrollment choices. As described above, we find that most people who are new to Medicare, and even some who assist Medicare beneficiaries, are wholly unfamiliar with the effects of these coordination of benefits rules. As such, we do not anticipate that requiring QHPs to pay primary when a person is eligible for but not enrolled in Medicare will significantly affect individual enrollment decisions. Further, for most people with Medicare, disincentives embedded in the Medicare program, such as lifetime Part B late enrollment penalties, exist to encourage enrollment when a person is initially eligible. When appropriate and advance education is provided, we find that these disincentives adequately serve to encourage enrollment in the insurance program most appropriate for a given individual.

Rather than inform these Medicare enrollment decisions, we instead find that current COB policies—namely those that allow "phantom coordination" with Part B—effectively serve to compound and worsen the effects of honest Medicare enrollment mistakes. **As such, we urge CMS to clarify that "phantom coordination" with Medicare Part B is an inappropriate coordination of benefits policy for individual market QHPs to implement, as the agency has done for small group employer SHOP plans.**

While we believe this interpretation is sound policy, as a practical matter, it will complicate beneficiary education for those who purchase individual market plans outside of an ACA-based Marketplace. For those whose individual market plans are not ACA-based, we would expect State-based COB rules to apply, meaning that in most States "phantom coordination" with Medicare Part B would be permissible under the NAIC COB model rules. We encourage CMS to make any such distinctions among individual market plans abundantly clear.

Finally, as noted in the NBPP, Medicare Secondary Payer rules have dramatically different provisions for ESRD Medicare beneficiaries. Separate treatment that reflects this different coordination scheme, including the 30-month coordination period and different enrollment and application options, is essential.

Thank you for the opportunity to provide comments.

[24] 45 CFR 147.104(e); 45 CFR 156.125; 45 CFR 156.200(e); See, CMS, "Frequently Asked Questions Regarding Medicare and the Marketplace," last updated April 2016), available at: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html at D8.
[25] 42 USC § 1395y
[26] NAIC, Group COB Model Regulation § V(D).